

A wide variety of respiratory exposures and underlying conditions are associated with organizing pneumonia. These include inhalation of toxic fumes, immunologic and connective-tissue disorders, inflammatory bowel disease, human immunodeficiency virus infection, common variable immune deficiency, radiation therapy, myelodysplastic syndrome, drug reactions, malignant diseases, bone marrow or solid organ transplantation, and others. Bronchiolitis obliterans organizing pneumonia, or BOOP, is a distinct pattern of reaction of the lungs to injury. However, evidence of bronchiolitis is variably present or entirely absent in some patients. Moreover, the term BOOP causes confusion with other forms of bronchiolitis obliterans. So we now classify the idiopathic form of BOOP as cryptogenic organizing pneumonia, or COP, and the secondary form as secondary organizing pneumonia, or SOP. Vasu et al, in their retrospective study of 33 patients, report that COP and secondary BOOP have diverse clinical and radiologic manifestations. Patients with secondary BOOP are more symptomatic. Patients with either COP or secondary BOOP have a good prognosis, and most respond to treatment with corticosteroids or by discontinuing the injurious drug. As pointed out in the editorial by Heffner, this report adds to the sparse literature that compares these 2 forms of organizing pneumonia. Our existing typology that separates SOP from COP may represent a helpful system in our present state of limited knowledge, but it should not establish that these 2 entities represent distinct lung diseases.

The need for more effective smoking-cessation interventions is not debated. However, access to these services can be problematic in real life. E-mail messages may be a convenient alternative to deliver smoking-cessation interventions. In their study, Polosa et al found that integration of e-mail consultation counseling in a smoking-cessation intervention is feasible and effective. Nearly 37% of those who participated in e-mail counseling remained abstinent at 6 months after the smoking-cessation program, which is comparable to other strategies. As Op't Holt points out in his editorial, this technology shows promise and has been applied to multiple other medical problems. It may be effective, but with some limitations and concerns. A frequently cited concern of patients and providers relates to the confidentiality and security of the e-mail communication and how e-mail communication makes its way into the patient record. As healthcare providers and their patients become increasingly wired, email is likely to be used increasingly as a means of communication between patients and their clinical teams.

We are pleased to publish 6 papers this month from the symposium "COPD: Empowering Respiratory Therapists to Make a Difference." This symposium was presented as part of the 2008 AARC International Respiratory Congress in Anaheim. As a group, these provide a state-of-the-art overview of chronic obstructive pulmonary disease (COPD).

The recommendations of the Global Initiative for Chronic Obstructive Lung Disease, or GOLD guidelines, have become the standard for prevention, diagnosis, and treatment of COPD. An important part of the GOLD guidelines is a classification of COPD severity based on spirometry. As Gold indicates, respiratory therapists are essential in the prevention, diagnosis, and management of acute and stable COPD if the goals of the GOLD guidelines are to be attained.

As MacIntyre points out, spirometric testing depends heavily upon the quality of equipment, patient cooperation, and the skill of the technologist performing the test. Spirometry should be considered a medical test and must be performed by trained personnel. As MacIntyre appropriately suggests, using spirometry to screen for obstructive lung disease and the effect of screening on patients' outcomes have yet to be demonstrated.

Inhaled pharmacotherapy is a critical component of the management of patients with COPD. Although it provides immediate relief of symptoms, no pharmacologic agent ameliorates the decline in lung function or changes the clinical prognosis of patients with COPD. As reviewed by Restrepo, a stepwise approach is often used for the management of stable COPD with inhaled medications. The 2 categories of inhaled drugs used in the management of stable COPD are bronchodilators and corticosteroids. Key to the effectiveness of these is proper use of the inhaler. Respiratory therapists play an important role in the care of patients with COPD by educating patients on the correct use of inhalers.

Respiratory therapists often have contact with patients with COPD who want to quit smoking but do not know where to begin. In their paper, Goodfellow and Waugh discuss issues related to tobacco treatment and prevention. Many patients want to quit smoking but struggle through a difficult cycle of addiction. Key to a successful smoking cessation program is education, along with pharmacologic interventions and counseling. The respiratory therapist plays an important role in asking patients if they are smokers and if they are interested in a smoking cessation program.

An important aspect of the care of patients with COPD is pulmonary rehabilitation. The rationale for pulmonary rehabilitation, patient assessment, components of care, and outcome measurements are described by Carlin. As he points out, identifying patients who are eligible for pulmonary rehabilitation, assessing patients prior to entry into the program, providing education regarding the patient's disease, and participating in the exercise and training programs are ways that respiratory therapists can be involved the pulmonary rehabilitation of patients with COPD.

As reviewed by Dunne, long-term oxygen therapy improves survival for patients with severe COPD. Equipment for long-term oxygen has changed in important ways in recent years. The newest approach to long-term oxygen therapy uses equipment that is self-sufficient and able to provide all of the oxygen needed to meet both stationary and ambulatory requirements. Because this equipment has operational and performance limitations, patients must undergo individualized pulse-oximetry titration to ensure optimum dosing under all conditions of use. Not every patient can be effectively oxygenated with every type of device. Dunne also appropriately makes the plea that long-term oxygen should be prescribed to target oxygen saturation rather than a specific flow, thus allowing the delivered dose to be based on the patient's individual needs as determined by their life-style and activities of daily living.

Irani et al report an interesting case of recurrent right-sided pleural effusion 2 years after a ventriculopleural shunt insertion. As Barreiro points out in his editorial, making a correct diagnosis for pleural effusions can be difficult, and understanding the various diagnostic techniques and their limitations is important in identifying the causes of the underlying disease process. The teaching case this month, by Dickson and Luks, is one of toluene toxicity as a cause of elevated anion gap metabolic acidosis.